Physical illness in people with mental disorders

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In a few months Cambridge University Press will bring out a comprehensive review of publications documenting the frequency of physical illness in people with schizophrenia (1). Other volumes, dealing with the frequency and types of physical illnesses in people with other mental disorders, will follow, probably in 6-monthly intervals over the next two to three years.

The trigger for the preparation of these reviews has been a personal communication from a physician working with the Doctors without Borders in a Central Asian republic. He felt desperate because he was unable to get sufficient resources to deal with the very high mortality of people with schizophrenia admitted to the central mental hospital in the country: according to his account, one person out of two admitted for schizophrenia was likely to be dead at the end of the year in which he/she was admitted for treatment. Some of the excess mortality would be due, like in other countries, to suicide, but a large proportion of those who would die would have infectious diseases (e.g., tuberculosis) as the main cause of death. Other physical diseases also have a higher prevalence in people with schizophrenia than in persons without it.

People with schizophrenia do not only have higher rates of physical illnesses than those without schizophrenia (2). They also experience greater difficulty in getting adequate health care. Mental hospitals in many countries are often lacking equipment that could help in making the diagnosis of physical illness as well as medications and other material that would make it possible to recognize and treat physical illness. Psychiatrists are reluctant to treat physical illness, perhaps as frequently as doctors in other medical specialties fail to recognize that their patients also suffer from a mental disorder or refuse to provide treatment for it.

The situation is not better in the instance of other mental illnesses. Depressive disorders are often associated with physical illnesses (e.g., cardiovascular diseases or diabetes) (3). People with dementia often have physical diseases and so do people who suffer from other forms of mental disorder or have an impairment of their mental functioning. The high rates of comorbidity of mental and physical disorders are only rarely taken into account in planning health services and in teaching health professionals.

Why people with mental illness are more likely to have a physical illness than the rest of the population is only partially known. Part of the answer to this question may be that some people with mental illness do not pay sufficient attention to their bodies and do not follow elementary rules of hygiene and disease prophylaxis. The fact that they often live in conditions of poverty and are exposed to considerable dangers of violence and abuse might also explain some of the excess morbidity and mortality from physical illness that they have. The fact that people with mental illness may be abusing alcohol or take drugs and that they are therefore exposed to the health consequences of substance abuse and diseases related to the manner of use of drugs (e.g., hepatitis) may also play a role. There remains, however, a substantial proportion of the excess physical morbidity that is not explicable by the above mentioned factors and it is therefore necessary to suppose that there are factors that facilitate the occurrence of physical illness and are inherent in people who have mental disorders. Changes in the immune system and hormonal unbalance have been mentioned as being among those factors, but it is obvious that more research will be necessary to unravel the puzzle of high rates of physical illness in people with mental disorders.

In many countries psychiatrists have taken off their white coats, shed the symbols of being physicians, forgetting that they are medical doctors – with a particular interest in mental symptoms but still essentially practitioners of a medical discipline. The creation of the specialty of liaison psychiatry is a sad testimony to the fact that only a small proportion of psychiatrists have an interest in dealing in a comprehensive manner with people struck by physical illness. There are no liaison internists, liaison dermatologists nor liaison surgeons: when invited to consult other colleagues, they simply do that without creating a subgroup that will be specially trained to do this. They remain internists or dermatologists or surgeons who advise their colleagues when necessary without being separated from the rest of their discipline. The existence of liaison psychiatrists is an unwise message to the rest of medicine: despite having a medical diploma, only a few among the psychiatrists are sufficiently well trained in medicine to be able to deal with patients who have a mental and a physical disease at the same time.

What should be done about this? First, we should obtain data demonstrating the magnitude of the problem of comorbidity and its consequences in different parts of the world, in different types of services and for different mental disorders. Parallel to the data collection, other courses of action could be taken. These would include a revision of the curricula for training health professionals, at undergraduate and postgraduate level. The implementation of changes of curricula in schools for health personnel takes a long time: it takes an even longer time if there is no pressure to introduce the changes. Introduction of obligatory screening for mental disorders in general health facilities and for physical diseases in mental health services might also increase the awareness of all concerned that action is

needed now. The methods of screening that would be used in this effort will have to be simple and easy to apply: in addition, however, their introduction should be linked to the development of mechanisms that will allow relevant treatment once comorbidity has been diagnosed. Stigma attached to mental illness leads to discrimination of mentally ill people in the health care system: the introduction of a comprehensive model of care might require the application of measures that would also reduce stigma. An important consequence of stigma is the low priority that is given to mental health care, resulting in very low levels of funding for mental health services: the demonstration that the simultaneous attention to and treatment of mental and physical illness improves the prognosis of both and lowers the cost of treatment might help to change this situation.

References

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